

<b>Teton School District 401 Effective Date September 1, 2020</b>	
<b>PPO Incentive Dental Plan for Idaho School Benefit Trust</b>	
<b>Individual/Family Deductible</b>	None
<b>Individual Benefit Period Maximum</b>	\$1,250
<b>Preventive Services</b>	<b>What you pay</b>
<b>Oral Examinations</b> One (1) examination every six (6) months.	<p>The percentage you pay for allowed preventive services will start at 30% and decrease annually by 10% to 0% for each consecutive year the Participant visits your dentist.</p> <p>If you do not visit your dentist every year the percentage you pay will increase annually by 10%, however you will never pay more than 30%*</p>
<b>Fluoride</b> Limited to one (1) application per benefit period and limited to Participant's who are under age twenty-six (26).	
<b>Sealants:</b> Limited to permanent posterior unrestored dentition of eligible dependent children under age sixteen (16) and limited to one time per tooth in any three (3) consecutive benefit periods.	
<b>X-rays, Bitewings</b> Once per benefit period.	
<b>X-rays, Complete Mouth Series or Panoramic x-ray</b> One (1) time in any five (5) consecutive benefit periods.	
<b>Prophylaxis (Cleaning)</b> Once every six (6) months. (Regardless of type)	30%*
<b>Basic Services</b>	<b>What you pay</b>
<b>Filings</b> Restorations involving multiple surfaces will be combined and paid according to the number of surfaces treated; same tooth surface restoration is covered once in two (2) benefit periods.	<p>The percentage you pay for allowed basic services will start at 30% and decrease annually by 10% to 0% for each consecutive year you visit your dentist.</p> <p>If you do not visit your dentist every year the percentage you pay will increase annually by 10%, however you will never pay more than 30%*</p>
<b>Extractions</b>	
<b>Root Canal Therapy</b>	
<b>Periodontal Maintenance</b> Once every six (6) months. (Regardless of type)	
<b>Scaling and Root planing</b> Once per quadrant of the mouth every three (3) benefit periods.	
<b>Occlusal Guard</b> One (1) appliance every two (2) benefit periods.	
<b>Osseous Surgery</b> Once per area of the mouth every three (3) years.	
<b>Space Maintainers</b> Limited to Participant's who are under age sixteen (16). Benefits limited to deciduous teeth. Includes all adjustments made within six (6) months of installation.	
<b>Major Services</b>	<b>What you pay</b>
Preauthorization required on all major services	
<b>Bridges, Inlays, Onlays, Crowns, Veneers, and Full or Partial Dentures</b> Five (5) year replacement.	50% of the allowed amount*
<b>Dental Implants</b> Including the implant body, implant abutment and implant crown – benefits may be available up to the Maximum Allowance of a standard complete or partial denture, or bridge. Implant body and abutment-limited to once per tooth per lifetime. Implant crown –five (5) year replacement.	

**\*By choosing an Out-of-Network provider you pay your cost sharing, deductible, and any difference between what Blue Cross of Idaho allows and what the Out-of-Network provider charges.**

The information in this Highlight Sheet is for informational and comparison purposes only. It is not a complete summary or description of benefits. Coverage is subject to the provisions of the corresponding Plan Documents and Summary Plan Description, which contains the detailed terms and conditions of coverage. Certain services not specifically noted may be excluded. Please refer to the Plan Document and Summary Plan Description issued for a more complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference or conflict between this Highlight Sheet and its corresponding Plan Documents and Summary Plan Description, the Plan Documents and Summary Plan Description will control. This Highlight Sheet is subject to annual update.